Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-09-B564-01
PREFERRED IMAGING MEDICAL CENTER 5920 FOREST PARK DALLAS, TX. 75235	
Respondent Name and Box #:	
DALLAS ISD REP. BOX # 42	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "…We received a short payment $203.22 for code 73718 which MAR is $826.41. Claim was sent for reconsideration with a copy of the DWC fee schedule per region…."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $203.22
3. CMS 1500
4. EOBs
5. Medical records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "Additional information is enclosed to further clarify why the prior reimbursement of $623.19 is correct…."

Principle Documentation:

1. Response to DWC 60
2. EOBs
3. Medicare radiology publication sheet
4. Trailblazer rate sheet
5. CMS 1500

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
3-25-09	73718-RT	193W & W1A	1, 2, 3, 4, & 5	$203.22
Total Due:				$203.22

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.203, titled *Medical Fee Guideline* effective for professional medical services provided on or after March 1, 2008, set out the reimbursement guidelines.

1. This service was reduced/denied by the Respondent with reason codes "W1A" (workers compensation state fee schedule adjustment-reimbursement per Rule 134.203/134.204-prior to March 1,2008, Rule 134.202) and "193W" (original payment decision is being maintained-upon review, it was determined that this claim was processed properly-previous recommendation was in accordance with the Workers' Compensation state fee schedule).
2. In accordance with Rule 134.203 (b) and (c) (1), effective for dates of service on or after January 1, 2007, the Deficit Reduction Act (DRA) of 2005 limits the TC payment for most imaging procedures paid under the Medicare Physician Fee Schedule to the amount paid under the Outpatient Prospective Payment System (OPPS). The provision applies to "TC-only services" and the "TC of global services". The PC is paid in full for all procedures. By billing the diagnostic procedure and omitting any diagnostic modifier, this represents the billing for the "WP".
3. A review of the CMS 1500 form identifies that code 73718-RT was billed with no diagnostic modifier. This represents the 'whole procedure' as being billed. In reviewing the EOBs and the disputed Table, a payment of $623.19 has previously been made. Pursuant to Rule 134.203, additional monies are owed.
    - 73718-RT: $53.68 divided by 36.0666=$1.4883 x $555.25=$826.41
    - MAR of $826.41 - $623.19 (previously paid)=$203.22 owed
4. * "If the multiple procedure reduction and/or OPPS cap applies to the TC of the service, there is no need to split the bill. Any applicable reductions/caps to the TC will be calculated with the allowed amount for the global service." * -Another words, when calculating the MAR for the 'whole procedure' of an imaging service, participants are not to separately apply the "OPPS" cap for the global/whole portion of the 'technical component', for the CMS/Trailblazer websites have included this 'OPPS' cap limitation within the 'participating amount' column (s).
5. Per review of Box 32 on the CMS-1500, zip code 75235 is located in Dallas County. The maximum reimbursement amount, under Rule 134.203 (b), is determined by locality.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code, Rules 134.1, 134.203
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $203.22 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER:

Authorized Signature | Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.